Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-28-01.
   b. The request was received on 8-13-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter requesting Medical Dispute Resolution
   b. UB-92
   c. EOB
   d. Medical Records
   e. Healthcare Network participation and service agreements dated 7-30-92, 4-23-92 and 8-1-92.
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60
   b. UB-92
   c. EOB
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-20-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 9-20-02. No fourteen (14) day response was noted in the dispute packet from the Carrier. However, the Carrier's three (3) day response is reflected as Exhibit II in the Commission's case file.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 9-6-02:
   "(Provider) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of

reimbursement deemed to be fair and reasonable by (Provider) is at a minimum of 70% of billed charges. This is supported by a managed care contract with '….' that is attached as Exhibit 1. This managed care contract supports (Provider's) argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable. This managed care contract exhibits that (Provider) is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services…."

2. Respondent: No position statement noted in the dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-28-01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $7,795.14 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $4,894.51 for services rendered on the date of service in dispute above.

5. The Carrier's EOBs/audit sheets denied any additional reimbursement as "S – M RECONSIDERATION PROCESSED USING FAIR AND REASONABLE STANDARDS".

6. The amount in dispute is $2,900.63 for services rendered on the date of service in dispute above, per the Table of Disputed Services.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…."

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee

guidelines."

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine which party has provided the most persuasive evidence of what is fair and reasonable. The Carrier has not submitted any evidence as to how they determined their reimbursement amount. No methodology was submitted as required by Rule 133.304 (i). The Provider, who has the burden as the Requestor, to prove its fees are fair and reasonable submitted a copy of a managed care contract indicating payment of 70% was to be paid. However, that contract is 10 years old. It does not provide current information. This contract alone does not discuss, demonstrate and justify that the payment being sought is fair and reasonable as required by TWCC Rule 133.307 (g) (3) (D).

The Provider has not provided sufficient information that supports its fees billed represent a fair and reasonable charge. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 10th day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll